Connecticut Vaccine Program

2015 Provider Profile

Completed forms can be FAXED to: 860-509-8371 or EMAILED to: DPH.IMMUNIZATIONS@ct.gov

All public and private health care providers who receive vaccine from the Connecticut Vaccine Program **(CVP)** must complete this form. This document provides shipping information and helps to determine the amount of vaccine to be supplied. The form is also used to compare estimated vaccine needs with actual vaccine supply. The Connecticut Vaccine Program will keep this record on file with the SIGNED **"Provider Agreement"**. The Provider Profile form must be updated annually or if: (1) the number of children change, or (2) the address of the facility changes. **Complete one Provider Profile for each office/site/satellite.**

Federal Employer Tax ID ____ ____ ------ ____ ____ ____ ____ ____ ____ ____	**Please Check One** Re-Enrolling in CVP ☐ New Provider ☐	**PIN** (If re-enrolling pin is required) ____ ____ ____ ____

Facility Name

Office Days and Hours Staff Available to Receive Vaccine Shipments

Monday	Tuesday	Wednesday	Thursday	Friday

Include any time during normal business hours when the office is closed and will not accept vaccine deliveries.

Type of Facility (check one)

☐ Local Health Department	☐ Birthing Hospital	☐ Primary Care
☐ Federally Qualified Health Center (FQHC) or Federally Funded Rural Health Clinic (RHC)	☐ Private Practice (Individual or Group)	☐ OB/GYN
☐ School Based Health Center	☐ Hospital Clinic	☐ Internal Medicine
☐ STD/HIV Clinic	☐ Other (please specify)	☐ Allergy
☐ Drug Treatment Facility	**Specialty (check one)**	☐ Urgent Care Center
☐ Family Planning Clinic	☐ Pediatrics	☐ Other (please specify)
	☐ Family Medicine	

Patient Enrollment and Insurance Status All practices must provide total patient enrollment numbers by age group and insurance status in order to receive vaccine from the CVP. New providers can give an estimate. Do not count a patient in more than one category and DO NOT use percentages. **Rows numbered 1 through 6 must equal the total patient enrollment by age group in row 7.**

	Birth to 1 yr.	**1 - 6 yrs.**	**7 - 18 yrs.**	**Total**
1. Number of Privately Insured Patients				
2. Number of Medicaid Enrolled Patients (HUSKY A)				
3. Number of Patients Without Insurance				
4. Number of Patients who are American Indian or Alaskan Native				
5. Number of S-CHIP Enrolled Patients (HUSKY B)				
6. Number of Underinsured Patients				
7. **Total** Number of **All** Patients in your practice who will be administered state supplied vaccine (must equal the sum total for rows 1-6 above)				

Data Source What data source was used to determine the total number of patients and insurance status provided above:

☐ Immunization Information System ☐ Billing System ☐ Electronic Health/Medical Records ☐ Other_____

Storage Units Please indicate the type of storage unit(s) used to store state supplied vaccine (check all that apply)

☐ Stand Alone Refrigerator Unit ☐ Stand Alone Freezer Unit ☐ Single Door Refrigerator & Freezer Unit (Dormitory Style)

☐ Double Door Refrigerator and Freezer Unit (top/bottom or side by side)

Temperature Monitors Indicate type of temperature monitors used in storage

☐ CVP Supplied Continuous Read Dickson Thermometer ☐ Dial Thermometer ☐ Liquid Temperature Probe ☐ Data Logger ☐ Other _____

Are you interested in registering for VTrkS (Vaccine Tracking System)? VTrkS is a web based vaccine ordering system developed by CDC.

Yes please send me information ☐

PLEASE remember to sign the *accompanying "Provider Agreement"*